***Testimony before House Committee on Health Policy re: Senate Bill 1019***
***November 29, 2016***
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Mr. Chairman and Committee members, thank you for the opportunity to testify today.

My name is Lyn Jenks and I am the President and CEO of Munson Healthcare Charlevoix Hospital. With me today is Dr. Gregory J. McBride, DO, a surgeon at Munson Charlevoix, and Duke Anderson, President and CEO of Hillsdale Hospital. David Seaman from the Michigan Hospital Association will be testifying and Mike Dosch from the Michigan Association of Nurse Anesthetists is also here to answer questions if you wish.

We am here today to provide testimony in support of Senate Bill 1019, a much-needed proposal that will eliminate a needless, outdated, and costly regulation requiring physician supervision of certified registered nurse anesthetists, or CRNAs.

We think it is *crucial* to make sure everyone understands very clearly what current regulations require and what this proposal actually does. Both current regulation *and* the proposal have been somewhat mischaracterized during this debate we don't feel it is appropriate to ask for your vote on a measure based on inaccurate information.

First – this debate has been characterized as though it is about *anesthesiologist* supervision of certified registered nurse anesthetists. It is not. The regulation here in Michigan, which actually is *not* in statute but resulted from an Attorney General Frank Kelly opinion on an insurance matter many years ago, requires *physician* supervision of CRNAs. *Any* physician. A podiatrist. A dentist. An obstetrician. All extremely qualified medical professionals, no-doubt; however, professionals that may have little or no formal training and experience in anesthesia. *That* is an important distinction.

Another extremely important issue to address right away is to dispel this notion that this debate is about patient safety. Certified registered nurse anesthetists are the main anesthesia provider in facilities across the state, every day. Study after study, such as those conducted by the Institute of Medicine and the Research Triangle Institute, have found *no* difference in patient safety or medical outcomes where supervision is not required. Additionally, I'd like to call your attention to a fact about CRNA liability insurance. CRNAs are required to have our own insurance and when the supervising physician signs the piece of paper, there is *no* assumption of liability on the part of the physician. But the point I wanted to make was relative to their insurance *premiums*. CRNA liability insurance premiums have gone *down*. While the practice of nurse anesthesia is safer than ever on a nationwide basis, it is even more so in the state of Michigan. On a nationwide basis, the average 2014 malpractice insurance premium for self-employed CRNAs was 33% less than it was in 1988. In Michigan, it was 63% less. When trended for inflation through 2014, the nationwide reduction in premium was 66%. In Michigan, the reduction was 81%.

It's a relatively simple equation – if patient safety is a concern and anesthesia service is risky when provided by CRNAs, insurance premiums would *not* be decreasing.

Further – Michigan is one of only 10 states that have a supervision requirement – *yes one of only 10 states.*

This is also where those opposed to the measure may take exception with the fact I just stated, about the 40 other states. To be clear, 17 of those 40 states have taken the next step in achieving full Medicare opt-out – but don't be confused...40 states require no supervision of CRNAs.

I think it is also important to note that, in addition to the 40 states where physician supervision is not required, the U.S. Military has no physician supervision requirement of CRNAs. This means that CRNAs are the front-line providers of anesthesia on battlefields and all U.S. military operations and are viewed by the United States Military as safe and competent providers.

This proposal will not *end* physician supervision of CRNAs in the state of Michigan. This proposal, instead, will provide hospitals and other facilities the ability to *choose* whether or not to require supervision based on their specific staffing, patient, and resource circumstances and needs. For many, this proposal will change nothing – anesthesiologists and certified registered nurse anesthetists will continue to work effectively in a team setting to provide anesthesia care. For other facilities, the flexibility this proposal would provide will eliminate unnecessary barriers to safe and effective care, while significantly reducing associated costs.

Now I'd like to clarify a mischaracterization and that's the whole "doctor in the room" notion. Those opposed to this proposal have sensationalized the situation and have used scare tactics with messaging along the lines of "if something goes wrong, don't you want a doctor in the room?" Only in very rare circumstances, such as for diagnostic tests, are CRNAs providing anesthesia services without the service being associated with a procedure that requires a physician...just like they are right *now*. So in the vast majority of instances, *of course* there is a physician in the room – the same doctor that, under current regulation is required to sign the piece of paper that he or she is "supervising" the CRNA, *that* doctor will be in the room. *I* am in the room.

Let's make sure that we are clear what we are talking about with this "supervision" requirement. To remind you of what was previously stated, this is not anesthesiologist supervision – it is any physician supervision. Such as me. So what that means is that I, with limited experience and training in anesthesia, am required to sign a piece of paper prior to *or as long as 30 days after* any procedure stating that I am supervising the plan for anesthesia service. There is no assumption of liability when I sign the form – the CRNA maintains his or her own liability insurance – and I completely trust the CRNA's plan of anesthesia...so my signature is a meaningless step in the process.

Let me be clear. I do not want to supervise CRNAs – they are competent, safe, knowledgeable, licensed, insured professionals and patients gain nothing from having me or any other physician supervise a CRNA. I fully trust the CRNAs with whom I work and can think of no reason they should not be able to practice to the full extent of their current license – to do what they do every day – without my signature.

Michigan has around 2,600 CRNAs. These professionals are already the largest providers of anesthesia services in many parts of Michigan, allowing patients in underserved, rural areas to have access to obstetrical, surgical, pain management, and trauma stabilization services.

By eliminating this completely unnecessary and outdated regulation, this legislation will increase access to health care for Michigan residents. It will reduce costs for Michigan residents. It will permit CRNAs to

practice to the full extent of what their license already provides for – and it will do all of this while maintaining every bit of patient safety.

The question has been posed several times, "what problem are we trying to address through this legislation?" There are multiple answers to that question, but most clear is to explain that by eliminating the supervision requirement, this legislation will provide the leadership team at my hospital and others the flexibility to develop and implement the anesthesia delivery processes that best-suits our specific staffing, patient, and resource circumstances and needs. For many, this proposal will change nothing – anesthesiologists and certified registered nurse anesthetists will continue to work effectively in a team setting to provide anesthesia care. For other facilities, the flexibility this Senate Bill 1019 would provide will eliminate unnecessary barriers to safe and effective care, while significantly reducing associated costs.

There are roughly 600,000 Michigan residents that have health insurance for the first time under the state's Medicaid expansion. Many of these patients will need surgery and are entering a health care system where access to surgical procedures is limited by unnecessary restrictions on anesthesia providers. A safe, smart anesthesia delivery model will give Michigan hospitals the flexibility to meet the increased need for surgeries from a growing number of patients.

An Anderson Economic Group study, a copy of which you have all been previously provided, finds that today "for nearly 600,000 Michigan residents, the only option for anesthesiology services within a 30-minute drive is a hospital or a facility without an anesthesiologist." At these facilities, anesthesia is being safely delivered by CRNAs who are practicing without a supervising anesthesiologist in the building or even in the county – let alone in the operating room.

CRNAs are unbelievably competent professionals that are focused on anesthesia care – their specialty. They provide their care with the highest level of safety and effectiveness based on education and training that I can simply not replicate.

Thank you again for your time. We will gladly answer any questions you may have.